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SOME POINTS REGARDING THE DIAGNOSIS OF UTERINE ANTEFLEX- IONS AND ANTEVERSIONS.¹

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PERHAPS upon no subject connected with the treatment of the diseases of women is there a greater difference of opinion among gynaecologists than upon the question of the practicability of remedying the forward displacements of the womb (anteflexion and anteversion), and relieving the symptoms arising therefrom, by the use of pessaries. One class of practitioners declare all supporters useless in such cases. The other class claim most excellent results from their use; of these latter, A will be enthusiastic over one particular kind; B will declare that the instrument which he has himself devised, different from all others hitherto in use, is the only one which he has found to yield satisfactory results, and will express astonishment that C should ever have invented *his* particular form of supporter, since it is wrong both in theory and application; while C, upon being interrogated, will perhaps express a similar idea of B's instrument as well as of that employed by A. With the existence of such differences of opinion among the uterine specialists it is no wonder that the average general practitioner is a little skeptical, at times, as to the real value of supporters in such cases.

Why is it that different practitioners hold such diametrically opposite opinions upon the subject? I believe that "error of diagnosis," or, perhaps, I should rather say "want of precision in 'diagnosis,'" is the cause. The anteflexion or anteversion of the one gyn-

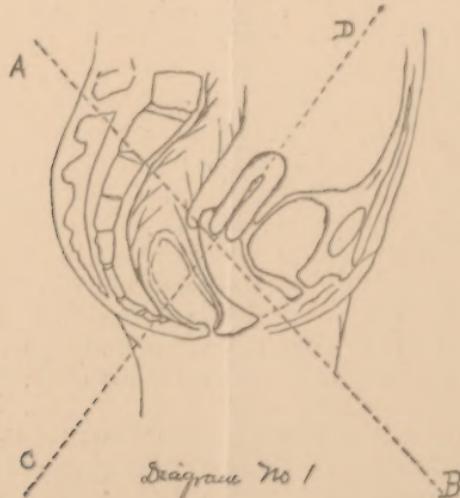
¹ Reprinted from the Boston Medical and Surgical Journal of February 9, 1882.

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æcologist, conditions which he finds but rarely, and then has but little success in treating, is a very different thing from the anteflexion or anteversion of his neighbor who diagnosticates these displacements very often, and easily relieves the great majority of them by the use of pessaries of one kind or another. Such displacements the first practitioner will also treat successfully, perhaps, but he will not consider that he has had to deal with either anteflexion or anteversion.

On making a uterine examination of a woman whose womb is in its normal position, the neck of the uterus is usually the only part of that organ to be felt by the finger in the vagina, unless the pelvic parts are forcibly pressed downward by the other hand upon the abdomen (bimanual examination).

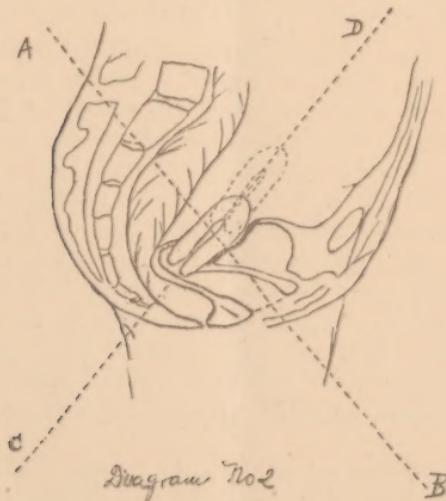
Now if, in his examination of a case, the physician's finger comes at once in contact with the body of the



womb, which can be plainly felt through the anterior vaginal wall, he is apt to conclude that he has to deal with a marked case of forward displacement. Feeling with his finger a sulcus on the anterior surface of the

womb, at or near the junction of body and cervix, he diagnosticates "anteflexion." Not feeling this place of flexion he settles to his satisfaction that the case is one of "anteversion." In point of fact, the great majority of such cases are neither "anteflexions" nor "anteversions," but simply instances of the "sagging uterus," so-called. The subject can be made plain by diagrams.

In the first diagram the line *C D* is drawn in the axis



of the uterus, which is in its normal position. The line *B A* is drawn in the axis of the vagina and indicates the direction which the examiner's finger naturally follows. No part of the womb can be easily reached per vaginam, save the cervix. In the second diagram the position of a "sagging uterus" is shown. It will be noticed that in this position its axis is but little if any changed from the axis of the womb in its normal position (represented by the line *C D*). But when the physician comes to make his vaginal examination, passing his finger in the direction of the line *B A*, the normal and usual direction of the vagina, he feels (through the anterior vaginal wall and the bladder)

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not the cervix uteri which he expects to find in this direction, but the anterior wall of the body of the womb, perhaps near its very top, and commonly he reasons, "The womb must be badly tipped forward, else I could not so clearly feel the fundus."

Now the cases of "sagging womb," at least the great majority of them, are easily relieved by the use of proper supporters, and many patients who have suffered much from such displacements, after wearing supporters for a while, can dispense with them, and have no return of the trouble. Hence we can understand how physicians who consider such displacements as anteflexions and anteversions can claim that they readily relieve these malpositions with supporters, and it does n't make any difference what kind is used, whether it be A, B, or C's particular choice, whether it be simple or complex, whether it be one of the many "anteversion" or "anteflexion" devices or a common lever pessary (and the last kind, being the simplest, is the best of all); anything which tends to press the uterus upward and lifts its weight off the overstretched tissues will afford comfort to the patient, provided that it be decently fitted, so as not of itself to cause pain and discomfort.

But it may be asked, How is it that a flexion can be felt at the junction of body and cervix if the case is not one of anteflexion? The explanation is simple. If, as is often the case, the uterus descends ("sags") so far that the cervix rests upon the floor of the pelvis, or, more precisely, the posterior wall of the vagina, the direction of the plane of the latter is such that it tends to press the neck of the womb forward. In certain cases, as the cervix is pressed forward the fundus falls backward, and a backward displacement results, but in many other cases the fundus remains in its proper axis, while the cervix alone is displaced from its normal direction. (See Diagram No. 3.) The result is the flexion which the examiner's finger detects, an "anteflexion of the cervix," if you choose so to call it,

but an "anteflexion of the cervix" purely secondary in its nature, and which requires nothing further in the way of treatment, as the rule, than that the uterus be so lifted that its weight shall not rest upon its cervix against the posterior vaginal wall. Indeed, I think the term "anteflexion of the cervix" applied to such conditions often deceives the physician as to the true nature of the case he has to deal with. Take the weight off the bended cervix, and you may be pretty sure that the latter will soon regain its normal position and axis, and that it will rarely, if ever, be necessary to perform "division of the cervix" with the knife in order to straighten the uterine canal, as has been done so often in the past in just such cases, and as is still advised in some of the textbooks as a regular procedure. The results obtained in such cases with properly fitted supporters are usually exceedingly satisfactory. Often as complete relief from the many pains and aches which the patient suffers can be afforded as in the most marked case of retroflexion, even.

Anteflexion and anteversion may of course coexist with "sagging" of the womb. The conditions are often combined in the same patient. When this is the case the physician may hope to afford relief with supporters in direct ratio with the preponderance of the "sagging" over the displacement forward; but in order to form a correct opinion of his cases he must be careful and not fall into the error we have pointed out, and conclude that he has to deal with a marked forward displacement simply because the fundus is plainly felt *per vaginam*, and he must remember that with a sagging of the uterus any degree of forward displacement seems, by digital examination, much greater than it really is.

With this explanation of the conditions so often wrongly considered anteflexion and anteversion, we



Diagram No. 3

can understand why certain so-called "anteversion and anteflexion" pessaries are highly praised by their various admirers and inventors, while others, equally competent, find them anything but satisfactory for *their* cases. Most of these instruments are supposed to force the fundus up towards its normal position, by pressure exerted through the anterior vaginal wall upon it (the fundus). But the tender bladder, is in the way, lying between this anterior vaginal wall and the uterus in such cases, and it is nonsense to talk of exerting enough steady pressure upon the anterior vaginal wall to force the fundus into position, when such pressure must act through the bladder, which, as the rule with such displacements, is already irritable. When any good results are accomplished by this class of supporters it is probably because they put the anterior vaginal wall upon the stretch, and, lifting it somewhat, they must also lift in a measure the womb to which it is firmly attached at the cervix; but the same result (the lifting of the womb) can be better brought about by a common lever pessary properly adjusted.

Where the uterus is displaced forward without material descent in the pelvis, a condition to which the unqualified terms anteflexion and anteversion should properly be restricted, fortunately a condition which is extremely rare, we have an entirely different matter to deal with. Here I have failed to find any kind of pessary satisfactory, and can hardly say what course I may pursue in the next case which may present. Intra-uterine stem pessaries, which are best dispensed with in all other displacements, are scarcely less unsatisfactory here.

Upon looking through the text-books, and seeing how the subject of pessaries is treated in them, one familiar with their proper uses cannot but wonder that practitioners who depend upon information obtained by reading the so-called "authorities" ever have any success whatever with them. Take, for example, two books much in use, Thomas's and Barnes's. In the

former is the well-known plate copied from Hewitt, in which Hewitt's anteversion pessary is represented as pressing up between uterus and bladder in an impossible way, while the pessary itself rests upon nothing. Barnes gives an equally curious diagram of the action of one of Thomas's inventions for anteversion. Here, again, the supporter floats in position sustained by some mysterious power. In both diagrams the instruments are represented as causing an amount of upward pressure against the anterior vaginal wall which in practice would seriously injure the parts in a very short time. Thomas figures (page 368, edition of 1880) the normal position of the womb with the close relations of bladder and cervix uteri, and on page 411 (same edition) an imaginary relation of the parts in anteflexion, in which latter diagram there is a space of several inches between the cervix uteri and the bladder, and the same convenient space is figured in most diagrams of anteflexion and anteversion pessaries in position; yet Savage¹ states: "The pouch of Douglas behind and the bladder in front, notwithstanding the yielding character of its uterine cellular connections, invariably follow the uterine cervix, maintaining unaltered relations with it, whatever be the nature of the displacement. This is actually a rule without exceptions, never disregarded without evil consequences."

In Barnes's work are three plates intended to show the application of a lever pessary for retro-displacement. Here, again, nothing seems to support the supporter. Two plates are given to show how an intra-uterine stem may be used to assist the lever pessary in keeping the womb in position in cases of retroflexion, when it is a fact that if a lever pessary is properly used such assistance is unnecessary.

When the leading works thus treat the subject of supporters, what can be expected of those who blindly attempt to follow their instruction?

¹ *Female Pelvic Organs*, page 54.

